CLINICAL PSYCHOPATHOLOGY VOL. 11, NO. 1, APRIL 1950

PSYCHOPATHOLOGY OF SEXUAL DELINQUENCY*

J. G. N. CUSHING, M.D.
BALTIMORE, MARYLAND

The psychiatric, the criminological and the legal literature offers little pertinent information about the psychopathology of the sexual offender. There have been reams written on the subject of the offender but it has been more the sociologic-biologic-statistical viewpoint that has been presented. There have been efforts to classify the sexual offender by the particular perversions practiced, and there have been efforts to classify the offenses of a sexual nature in a broad general pattern. However, the authors of such systems attempt to break up a broad impulse into the detailed mechanism by which the end result is achieved. Something of this sort would result if we were to follow that technic of classifying the processes of digestion by whether or not it is a ham sandwich or a turkey which is being digested. The end results are the same although the original proteins vary in their structure.

It is my feeling that if we were to look at sexuality as being one of the primitive and original forms of human expression, instinctive, which it certainly is, along with sleeping, eating, excreting, breathing, etc., we might achieve a different attitude. Freud, in his "Three Contributions to the Theory of Sex,"[11] has done pretty much this and has developed a pyschopathology, if you please, of normal sex functions. Now this psychopathology can very well be applied to the things that we determine as sexual offenses. However, then we end up with the same pathology which lies behind the individual who is living an offenseless sex life. The things that apparently make the difference first of all between the human being of 1948, in America, specifically in Baltimore, and the cave man of say 8000 B. C., is that 10,000 years' interval in which he has developed mores, "culture," social philosophies and religious philosophies. Along with all of these dignities which he has accreted through the centuries, the human being has also acquired inhibitions, repressions, suppressions, and all the other well-known psychopathologic paraphernalia, so that the attitude of the human being of 1948 is encumbered by the dross of generations of all of these philosophies, cultures, inhibitions, etc., to such an extent that he forgets that, stripped of his clothing, he is still the same naked human

*Read before the Neuropsychiatric Section of the Medical and Chirurgical Faculty, at the Symposium on Sexual Delinquency, December 9, 1948.

being who was on the earth ten thousand years ago, has the same sexual apparatus which functions in exactly the same way and that these inhibitions, cultures and philosophies are simply coverings which he, like Adam, donned as a fig-leaf protection.

There have been, in all these philosophies and cultures, two antagonistic interpretations of sex. First there has been the hedonistic doctrine that sexual activity is justifiable on the basis of pleasurable returns and the immediate end, and then, antagonistic to this, is one that sex is only a means of procreation and is to be had for that purpose only, after all the social mores have been satisfied. Now the end result of both interpretations is essentially the coaptation of the genital mucous membranes of a man being and a woman being. The fact that this union of the mucous membranes stimulates the man to produce sperm which may, or may not, unite with an ovum in a woman, seems to be lost sight of in both interpretations. The anhedonistic school takes the attitude that this coaptation is only proper after certain rituals and/or incantations have been said over the uniting couple and then only if the union is fruitful. The hedonistic doctrine inclines to the idea that the end result, whether it is the coaptation of the mucous membranes of man and woman, or the stimulation of either set of mucous membranes either by the owners thereof or someone else, is the prime requisite because of the pleasure received by that stimulation.

There is, however, another possible interpretation of sex, and that is, that it is a normal biologic function which is acceptable in whatever form it is manifested. This, as Kinsey[3] points out, has hardly figured either in general or scientific discussion. "By English and American standards, such an attitude is considered primitive, materialistic or animalistic, and beneath the dignity of a civilized and educated people." The trend of today is a little more toward an adoption of such a biologic viewpoint and it is probably due to the Freudian discussions rather than to any effort on the part of the biologists that there is such a trend.

"Since English-American moral codes and sex laws are the direct outcome of the reproductive interpretation of sex, they accept no form of socio-sexual activity outside of the marital state; and even marital intercourse is more or less limited to particular times and places and to the technics which are most likely to result in conception."[3]

"Specifically, English-American legal codes restrict the sexual activity of the unmarried man by characterizing all pre-marital, extra-marital and post-marital intercourse as rape, statutory rape, fornication, adultery, prostitution, association with a

prostitute, incest, delinquency, a contribution to delinquency, assault and battery, or public indecency—all of which are offenses with penalties attached. However it is labelled, all non-martial intercourse is illicit and subject to penalty by statute law in most of the states of the Union, or by the precedent of the common law on which most courts, in all states, chiefly depend when sex is involved. In addition to their restrictions on heterosexual intercourse, statute law and the common law penalize all homosexual activities and all sexual contacts with animals, and they specifically limit the technics of marital intercourse. Mouth-genital and anal contacts are punishable as crimes whether they occur in heterosexual or homosexual relations and whether in or outside of marriage. Such manual manipulation as occurs in the petting which is common in the younger generation has been interpreted in some courts as an impairment of the morals of a minor, or even as assault and battery. The public exhibition of any kind of sexual activity, including self-masturbation, or the viewing of such activity, is punishable as a contribution to delinquency or as public indecency."[3]

From what we have to say here, it would then appear that the psychopathology of the sexual offender is not actually the psychopathology of an individual but the psychopathology of a culture, and that what we term sexual offenses are indeed stimulated, aided and abetted by our religious views, our cultural attitudes and our social structures.

The penalties enforced in all of these sexual activities which are non-marital, are in reality a defensive measure imposed in the most part by those individuals or groups whose cultural, social, and religious inhibitions are outraged by the activities of others. In many instances sentences are imposed by judges, justices and other law-enforcement officers for activities in which they themselves have at one time or another in their lives participated and/or which they know are common to a large percentage of the general population. This is particularly true in regard to punishment of male sexual offenders. The punishment of the female sexual offenders, while it carries the same weight supposedly in our laws, and there is just as much possible variation in the female sexual life as there is in the male sexual life, is carried out in a small percentage of cases.

It is noted in Kinsey[3] that there have been occasional court decisions which have attempted to limit the individual's right to solitary masturbation, and in the statutes of at least one state there is the rule that encouragement of self-masturbation is an offense punishable as sodomy. There have been penal commitments of adults who have given sex instruction

to minors, and there are evidently some courts who are inclined to interpret all sex instruction as a contribution to the delinquency of minors. In institutions, state-controlled and private, school and otherwise, the administration not only has been authorized but in some unauthorized instances has established rules of sexual behavior which go beyond the definitions of courtroom law. I have known of situations where severe physical punishment has been imposed for so-called "self abuse." Kinsey has histories from at least two institutions which imposed equally severe punishment for nocturnal emissions. Kinsey also reports that the United States Naval Academy at Annapolis considers masturbation sufficient grounds for refusing admission to a candidate.

In England the old English law is acceptable and offenses of a sexual nature are classified as follows:[2]

1. Unnatural offenses—that is, carnal knowledge of any animal and carnal knowledge by a man of a man, or a woman per anum. Any person above the age of 14 years who permits himself or herself to be so carnally known is a principal in the first degree.
2. Attempts to commit unnatural offenses—including assaults with intent to commit unnatural offenses, indecent assaults upon male persons, and male persons soliciting for immoral purposes.
3. Indecency with males.
4. Rape—that is the offense of having carnal knowledge of a woman against her will by force, fear or fraud.
5. Carnal knowledge of a female idiot, imbecile, defective or lunatic. Indecent assaults on females.
6. Defilement of girls under 13 and of girls aged 13 and under 16 years.
7. Incest.
8. Procuration—including living on the earnings of prostitution, detaining women in brothels, etc.
9. Abduction.
10. Bigamy.
11. Prostitution.
12. Indecent exposure.

This is as good a legal classification as is possible to find and in various modifications is pursued by most of the states in our country as their basis for classification.

Haines, Hoffman and Esser,[10] in a paper presented in May 1948 at the Washington meetings of the American Psychiatric Association, discuss the Criminal Psychopath Law of Illinois. They state that in their opinion the diagnosis of a sexual psychopath is based on the following points:

1. He must have been guilty of an aggressive sexual act against minors, or an aggressive sexual act against society. It must be:
2. A continual behavior pattern.
3. Not a mutual sexual relationship between adults.
4. Not an isolated sexual act.
5. Not alcoholism.
6. Not insanity or feeblemindedness.

The psychiatrist, on the other hand, attempts a rather more simple classification in which he uses broad groupings, such as perversions, borderline cases and incest. In perversions are classified the disturbances in the development of the sexual instinct. Here we take into account the fact that a majority of sexual perverts do satisfy their sexual desires without being brought into court. Of course, the possibility that the attention of the outside world would be aroused is greater with some perversions than with others, depending upon which of the social mores are offended at the time and how much hue and cry is raised.

According to the psychiatrist there are two cases in which the pervert may become a public nuisance, one is when he himself is not happy in his sexual behavior and can allow himself gratification only if punishment is expected to follow. The other is when there are strong aggressive tendencies against society which are expressed in the pervert actually in the same way that hatred against authority is expressed in other delinquent acts. Those perverts, therefore, who come before a court are in many cases persons with a tendency toward antisocial character formation or who suffer from neurotic character formations in addition to their perversions. We have not the time to go into it here, but I think it is agreed by most psychiatrists that perverse sexual behavior, antisocial character formations and neurotic disturbances all have their root in factors which disturb early and instinctive emotional development. Therefore we find several of these things in combination rather than one alone.

The second group, borderline cases, are those which on superficial investigation cannot really be classified among the perversions. Actually only an examination which takes into account the unconscious motivations could decide whether here the behavior is due to external circumstances or solely to a so-called perverse urge or impulse. In all cases of sexual assault from rape to the molestation of women, the behavior may be caused by external circumstances, that is by the impossibility of obtaining sexual satisfaction in the ordinary way so that increased aggression is necessary to satisfy a normal sexual urge. Or it may be due to a sadistic perversion, that is, the assault

may be a necessary original condition for gaining sexual satisfaction.

The same two factors of external circumstances and aggressive drives are very often at the basis of indecent assault by men on small girls. Most writers have noted that in cases of this kind the man involved was usually not very young and his sexual capacities were weak. And we do have the problem in our midst of the old men who are apprehended and sentenced to penal institutions as sex offenders. In this state they are usually charged with assault with intent to rape. In other states they are charged with contributing to delinquency by fondling minors of either sex. Among the few whom I have seen personally, there is very good reason to believe that these men are impotent and that it would be impossible for them to carry out the sexual act even though they might want to. It has usually been that there were opportunities of being with young children and in these few instances at least, it was a drive to be accepted by someone with whom they could be intimate without having to feel unmanly. Actually this is not very acceptable to the parents of the young children who quite rightly demand protection of the minor from such molestation. Some such acts are committed by individuals suffering from senility or other organic brain changes, but these are a minority of convicted offenders.

Of course, there are other types of sexual offenses by adults with young children and these are frequently based upon the remnants of normal infantile curiosity, that is, the curiosity to see how a small girl or boy is built. Such an act, of course, is committed by an emotionally immature individual.

The third large classification into which psychiatrists tend to group sexual offenses is incest. Here the relationship is considered to be between father-daughter, brother-sister, or mother-son. They appear rather rare according to our court statistics because they are difficult to prove in the first place. It is difficult to arrive at corroborative evidence and frequently the female involved, herself feels much too guilty to bring charges, or she is just too fond of the aggressor to bring herself to furnish sufficient proof. I have examined, in the past ten years, at least 13 cases of known incestuous relations, which have gone on over a period of time in each instance. And out of those cases which I personally saw there was a definite psychotic deviation in one or the other of the individuals involved. This does not mean, however, that there are not incestuous relations in the absence of psychosis. In intensive psychotherapy with neurotic individuals, we not only hear of incestuous fantasies but we quite frequently hear of instances of brother-sister incest relationships. Needless to say the aggressor is not always a male.

None of these situations which we have discussed above, that is the perversions, the borderline cases or the incestuous relations, takes into account the sexual offense which is accompanied with crimes of greater violence, definite physical assault or murder. These, of course, are the ones which offend the whole community and I might add even the psychiatrists. They are frequently the detonator which arouses the community and sets the public officials and the judiciary to demanding the arrest of all sex offenders in the community, and precipitates the hue and cry for special institutions for the so-called sexual delinquents. These officials rarely take into consideration that if they are going to commit everybody who has committed *illegal* sexual acts, they are going to commit some 90 per cent of the population. Nevertheless, the sex case which has involved a forceful rape or a death following a sexual relation which is not a sexual offense per se, has no more special sexual psychopathology than has any other murder or forceful assault.

As stated above in discussing the perversions, the pathology is rather a combination of the dynamic emotional forces of the individual which come into conflict with more or less rigid cultural group patterns. Because the dynamic emotional forces are totally individual and because the customs of a culture are rather fixed, we must know more of the individual in order to outline the particular pathology involved in a particular crime.

If we are to understand the psychopathology in regard to these offenders whom we are discussing tonight, then we must first of all evaluate the cultural, social and religious aspects of the environment in which the act has been perpetrated and in which the individual has been reared. Secondly, we must concern ourselves with the emotional development of the individuals concerned in the act. It is only by a combination of these that we can come to any conclusion concerning the pathology of the sexual offense and even then we cannot in any scientific phraseology make a broad general statement which will cover the total situation as to why there are sexual offenders. It must be evident from this that we cannot group all those who are convicted of sexual offenses to an institution for treatment, nor can we commit them to an institution for confinement. So the problem then becomes one of better social education for those who can assimilate it and better standards of living for the general mass of the population, plus a more relaxed general cultural philosophy, without implying a gross laxity of the moral codes.

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DEBTS OF GRATITUDE PAID IN "GUILT DENOMINATION"

EDMUND BERGLER, M.D.

"The conscience of some people does not prevent them from anything," a wit once said, "it just spoils the pleasure."

This witticism is often only the beginning; some people enlarge upon it with a peculiar intrapsychic bargain: a conflict caused by having to do someone a good turn in order to repay a heavy debt of gratitude. They do not perform this good turn, but nevertheless suffer from intense reproaches of conscience because of the refusal. The end result remains the refusing action, but now accompanied by the feeling of being square with the refused person simply because the refuser, himself, suffered so many pangs of conscience before the act of refusing. In other words: an external debt of a moral obligation is paid for with internal guilt denomination. This, of course, does not help the refused one; the refuser, however, achieves vindication before himself. Frequently, the "facts of the case" (meaning the refuser's inner conflict on this point) are later communicated to the refused one.

At first glance, the mechanism of "cash payments of debts with guilt denominations" reminds one of "conscience money," a good deed executed exclusively because of inner guilt. On closer observation, one detects that the mechanisms are not only not identical but diametrically opposed. Conscience money helps the victim; guilt denomination payment (or no actual payment) damages the victim. Conscience money is externally visible in an action; guilt denomination is an internal deal occurring within the refuser himself, characterized by lack of external action.

I first observed this mechanism at work in an acquaintance who, according to his own estimation, owed me a debt of gratitude: "more than you have the slightest realization of." This acquaintance, a highly cultured and correct man, reiterated his everlasting gratitude for a protracted series of completely unselfish acts on my part (contents of which are immaterial to the case in point). I never asked for anything in return with the exception of one small favor, and even this one was dictated more by our interest in a common cause than for any other reason. In other words the request was more or less of an impersonal nature. The gentleman's reaction to the request was first to promise, then to procrastinate, and finally to lapse into complete inactivity. In a letter written several months after the original request was made (meanwhile he continued to accept my unselfish favors), the acquaintance informed me that Providence had delivered him from "the insoluble conflict";

he had just heard that it was too late to comply with my modest request. To quote from his letter: "Well, in the upshot, I am, I have to confess, more than a little relieved. For the quite serious conflict was this: on the one hand, I not at all want to . . . (do the requested), although well aware that I ought to want to . . . . On the other hand, I could not possibly refuse . . . , if you wanted me to do it—seeing that I owe you more than you have the slightest realization of. So, from this all but insoluble conflict I am delivered—and I hope you will not misunderstand my joy thereat—by . . . that Providence that shapes our ends, rough-hew them how we may." Although the writer acknowledges in the passages I have deleted that he has done extensive damage not only to me but to our common cause as well, he goes on, as if nothing had happened, to ask in many pages for the continuation of my unpaid and unreturned favors.

At first glance the letter gives the impression of an amazing mixture of hypocrisy and cynicism, but since I know the gentleman quite well I am convinced that this superficial impression is incorrect: he informed me earnestly of his protracted inner conflict and of his now being "square" because of his suffering brought on by this conflict. I further realized that being a really sensitive and fine person he would not have otherwise asked for a continuance of favors as he had done in his letter. Seemingly he was conscious of all this; the only thing not conscious to him is his unconscious masochistic provocation: undoubtedly he asks for a "kick in the jaw." Otherwise, he was quite honest in his feeling that—according to his strange psychic mathematics—he had paid all he owed me by having fought his conflict.

Naturally, one wonders about the naivete displayed in the letter. What was the purpose in the giving of the information? Granted unconscious provocation, there is still more to it: it contains also a plea; "give me your absolution." This can only mean that a small part of guilt is unresolved. The decisive part, however, is absorbed (he paid in guilt denomination).

It was my conviction that subjectively my acquaintance did not feel guilty; it was this that prompted the tenor of my reply. As tactfully as I knew how (I did not press the point as I otherwise would have) I reminded him that in addition to Providence perhaps the mechanism of "guided miracles by procrastination" was also involved; my request had been made months before, when it had not as yet been "too late."

Having now digested this peculiar psychic mechanism of my acquaintance, I asked myself whether I had not encountered it earlier in neurotic patients. Being highly interested in problems of unconscious conscience[1] I wondered how I could have

[1]See my books: The Battle of the Conscience (Washington Institute of Medicine, Washington, D. C., 1948) and The Basic Neurosis (Grune & Stratton, New York, 1949).

overlooked it. The answer to these questions was this: I had encountered the mechanism previously and had misunderstood it, the misunderstanding arising from the fact of the masochistic admixture being of so obvious a nature. In other words, I assumed it was the typical masochistic provocative technic, which it contains, but overlooked the part played by "guilt denomination" as described above. The reason for the oversight was simply that we do not credit sufficiently the fact of human naivete.

We are all familiar with Freud's classical description of "exceptions": people who suffer so much that they derive the right to mean actions from that suffering. The mechanism has been exemplified by Freud with Gloucester's famous monologue in Richard III. Here was a second source of error for myself; I overlooked the bargaining technic of the unconscious Ego (aside from putting the mechanism on the balance sheet of psychic masochism, the "exceptions-technic" clouded the picture). A third source of error was in the overlooking of the "two-ways-technic" described by myself for criminal actions[2] (some criminals show no emotional involvement in the form of guilt are even remorseless and cynical after their criminal actions, because the punishment was beforehand—unconsciously—calculated in the criminal deed—in the inner acceptance of punishment).

All this is merely an explanation for the overlooking of the guilt denomination mechanism. What about the material itself? First of all, the discrepancy "big debt of gratitude—refusal of a small favor" has to be specified. The refusal of the "small favor" has a case history in itself. The request provokes in the donor who refuses to be a donor an inner conflict which is only secondarily rationalized (I avoided this deduction in the case of my acquaintance simply because he had not been analyzed, hence everything found as reason would be merely speculation, therefore worthless).

In analyzed cases the story reads differently. We are then in a position to find these reasons and to analyze them. Unfortunately, the explanation in each case is a long-drawn-out affair, hence one representative example will have to suffice: A young homosexual writer, Mr. A., blocked in his productivity[3], was recommended to me by a friend of his, a Mr. B., who suffered from the identical perversion and the identical writers' block (he was a writer of factual articles for magazines). B. was in

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[2]See Suppositions About the Mechanism of Criminosis (Journal of Criminal Psychopathology, 1943); Crime and Punishment (The Psychiatric Quarterly, 1945); also my contribution to Lindner Seliger's Handbook of Correctional Psychology (The Philosophical Library).

[3]See The Writer and Psychoanalysis (Doubleday, New York, 1950).

analysis first and he was cured. After analysis he achieved moderate success in the limited field of magazine articles, lost his homosexuality, married, and was quite content. He began to write a novel, although his main field was journalistic in scope. He was very grateful to analysis and admitted freely to whom and to what he owed his renewed productivity. B. recommended that his friend A. enter analysis after the latter, in a suicidal mood, confessed to him his plight: sterility in productivity. At this point B. (he was still in analysis) admitted for the first time to A. that he was being treated and sent A. to me. It should be stressed that the admission that he was being treated was a great "sacrifice" for B. Originally, he wanted to keep his analysis a deep secret. He stated that his admission of it to A. was only because his friend was suicidal. A. had at that time a deep appreciation for B.'s admission of his secret.

During A.'s analysis the following incident occurred: through a book he had written while still in analysis, A. became quite well known, one might say half famous, and in an outburst of gratitude he thanked B. profusely for having shown him "the living example of the efficacy of analysis," and claimed "that this example, and this alone, pushed me into analysis" (quotes from a letter).

Some time later, B. finished his own novel and asked the now famous A. for a few pre-review lines to be used as an advertising "blurb". The unexpected happened: the deeply grateful A. quite cautiously told B. that he would have to think it over and let him know.

In analysis it became visible that A. was caught on both horns of the dilemma: the gratitude he owed B. and the "express wish" to refuse the few friendly publishable lines requested by B. This introduction, even in A.'s objective opinion, was deserved as he liked B.'s work; subjectively it was even more deserved because of the gratitude he felt. He reasoned in this manner: B. "made the mistake" of being open about his analysis, of not keeping it secret; A., on the other hand, would never admit this fact. Therefore, he reasoned, by writing the words of commendation he would be indubitably associated with B. in the mind of both the public and the critical world, and because of this association the suspicion might be aroused that he, too, was in analysis.

A. soundly tortured himself with his conflict of outdistancing his gratitude and with the "analytical compromising" of B. and his attempt to remain the "nice fellow." During the analytic discussion of this conflict, something unexpected happened: A., the patient, went to B. and told him quite frankly why he did not want to give B. the introductory lines he wished.

Whereupon B. told him, also quite frankly, that he considered him an "ungrateful dog," and then, quite appropriately, threw him out. A few moments later B. called him back, and apologized by saying that obviously a neurotic conflict was involved in the ungrateful attitude and suggested to A. that he analyze the incident with me.

The amazing feature of A.'s behavior was that he harbored the strange conviction that "it was unfair (on B.'s part) to have brought him into that conflict in the first place." He also felt quite justified in his refusal to grant the small favor, constantly stressing the qualms of conscience he had experienced in the last two weeks of indecision. The peculiar fact, that of explaining personally to B. his plight, was dismissed by A. with the statement that he does things the "open way."

At that time I interpreted A.'s behavior as masochistic provocation, which it was.[4] His lack of gratitude belonged in the chapter of neurotic ingratitude which has a complicated substructure.[5] I remember also that A.'s anger and indignation and his constant stressing of the deep suffering caused by B.'s request, at the time, struck me as peculiarly naive and rather funny. I told him the old story of the millionaire who calls for his butler to eject a supplicant with the dictum: "Throw him out, he breaks my heart . . ."

Analysis of the incident brought out two facts. First (and this was not fully conscious to him) A. did not want to be associated with B., not because of the danger of having to admit that his renewed productivity was "artificially produced" via analysis, but because of the homosexual connotation. A. also feared that his own past could be indirectly divulged. At that time, another ex-patient of mine, having written a successful "postanalytical" book, freely admitted in an interview in the *New York Times* that he owed his productivity to Freudian analysis.[6] I contrasted A.'s behavior with that of the interviewed writer, pointing out to him that deeper motives must have been involved in his own reticence.

These deeper, hence infantile, motives could be found in recollection of A.'s fourth year of childhood, and constituted the second reason for his ungrateful behavior. At that time he was caught by his mother in the company of his younger brother in mutual masturbation. With his mother's approach A. at once started to preach to his brother that it was "naughty" to do such a thing, acting all the while as if he himself did not participate in the "game." Mother, wise to the trick, punished

[4] I told him ironically that a line of the poet H. Heine applied to him: "Gruess mich nicht unter den Linden," which in his case might be loosely interpreted to mean: "I don't want to know you in public, only in private."

[5] See Psychopathology of Ingratitude, Diseases of the Nervous System, 1944.

[6] See Basic Neurosis, pp. 192–193.

the boy severely. The child took the punishment, and yet persisted for weeks in preaching to the younger brother, always pretending that he himself was innocent.

After working out of the masochistic substructure, the projection of his own guilt, hypocrisy, etc., A. apologized to B. and wrote a few enthusiastic introductory lines, later published in B.'s book.

The out-distancing of one's own guilt, so obvious in both cases (that of the acquaintance and of A.) shows that the mechanism of guilt denomination is one of the hundreds of inner defense mechanisms with which the unconscious Ego tries to make the life of its "client" easier. It also warns of simplification: we have still a great deal to learn. Furthermore, the mechanism shows that in the conflict "big debt of gratitude—refusal of a small favor" infantile elements invariably enter the picture. I could observe this in a series of cases.[7] It also proves that moral indignation alone—Mr. B. considered Mr. A. an "ungrateful dog"—contributes little to the fantastically complicated mosaic of "*The Battle of the Conscience*" raging in every human being from the cradle to the grave.

251 Central Park West
New York, N. Y.

[7]See Typical Unconscious Reactions to Sickness and Death in Acquaintances (Quarterly Review of Psychiatry and Neurology, 1948).

INSOMNIA, PSYCHOGENIC ASPECTS: A SYMPOSIUM*

"A flock of sheep that leisurely pass by,
One after one; the sound of rain, and bees
Murmuring; the fall of river, winds and seas,
Smooth fields, white sheets of water, and pure sky
By turns have all been thought of, yet I lie
Sleepless; and soon the small birds' melodies
Must hear, first uttered from my orchard trees;
And the first Cuckoo's melancholy cry.
Even thus last night, and two nights more, I lay,
And could not win thee, Sleep! by any stealth:
So do not let me wear tonight away:
Without Thee what is all the morning's wealth?
Come, blessed barrier between day and day,
Dear mother of fresh thoughts and joyous health!"

William Wordsworth, "To Sleep"

INSOMNIA IN RELATION TO GUILT, FEAR AND MASOCHISTIC INTENT

LEONARD GILMAN, M.D.†

There is always a reason why an individual habitually complains of inability to sleep; yet the patient often denies any disturbing or unpleasant thoughts other than such thoughts as would be the expected result of the discomforts arising from sleeplessness. Most characteristically one obtains from the patient the "explanation" that there is nothing in his mind at such times but an extreme desire for sleep, and annoyance, irritation, and feeling of frustration at his inability to do so.

In regard to the clinical aspects of insomnia, one striking fact becomes evident at the onset: namely, patients usually exaggerate the degree of severity of their insomnia, at times to an absurd degree. The most interesting point is the almost universal tendency of insomniacs to show depressive symptoms, or mood (affect) disorders; rarely does one find an exception to this. Depression in itself may be attributed by the patient to the fact that he does not sleep, whereas further investigation

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*Discussed before The Washington Society for The Advancement of Psychotherapy, March 10, 17 and 24, 1948.

†Attending psychiatrist, Mountainside Hosipital, Montclair, N. J.

of the case reveals that both the insomnia and the depression are parallel and independent expressions stemming from other underlying factors.

A review of our clinical material reveals that insomnia results principally from three types of factors: (1) fear; among the fears the most common are fear of death, fear of unconscious incestuous desires and their dream-expression during sleep, and fear of homicidal or suicidal wishes; (2) the guilt factor, generally unconscious, is most commonly related to the fears mentioned, perverse sexual interests and inferiority; (3) masochistic intent, the unconscious motivation for self-punishment which leads the patient into a state of self-torture (insomnia) by denial of sleep which is recognized to be a primary biologic necessity. In the treatment of insomnia, even by means of placebos, there is always some degree of transference between the therapist and the patient. For example, the power of suggestion by placebos obviously represents a symbolic substitution of a worthless capsule for an interpersonal relationship, and the therapist himself becomes a substitute or symbol for the habitual tucking-in-bed process of early life in an individual who is in a child-like dependency state. This relationship, of course, represents a regressive phenomenon and, in those instances where placebos are effective in producing sleep, constitutes an emotional situation as unhealthy as the original insomnia.

Suggestion has its role in all forms of psychotherapy and in each instance it is related to transference between the subject and the suggestor, so that the practitioner who offers the pill or sedative plays a much more profound role than appears at first glance. His pill which puts the patient to sleep night after night, and without which the patient remains insomniac, may represent the unconsciously longed-for caress so regularly administered by the parents during childhood. However, although there is always some degree of identification between the patient and the therapist, therapeutic results cannot be expected on this basis alone, and a searching investigation of the patient's underlying emotional conflicts and unconscious fears, guilt and masochistic desires is necessary if lasting relief of insomnia is to be attained.

OEDIPAL JEALOUSY AND PASSIVE DEPENDENCY STATES IN INSOMNIA

DR. VALENTINE A. UJHELY*

The two cases to be presented show, beside other anxiety or guilt or fear-of-sleep mechanisms, the role of unresolved and thus neuroticizing influences of the Oedipus situation, connected with a dependency reaction attached to the not-hated parent. The oedipus is a normal evolutive epoch in the phallic stage, when instinctual libidinous drives bring about a self-desired gratifying orientation toward the opposite-sexed parent. Hostility evolves toward the similarly sexed parent, because the child wishes to own the other, without a rival.

Case One

A 10-year-old girl had had but little contact with her father for the last six years until his recent return from overseas. The mother, a beautiful, energetic, intelligent and expert horsewoman of the society set, controlled this child uniquely, also the 14-year-old pubescent brother. At the age of 5, the girl was sexually traumatized when a male servant inserted his finger in the child's genitals. Later the child witnessed some strange "goings on" under the igloo-like arrangement of sheets over the brother's bed, the boy gazing at lewd pictures illumined by a flashlight. When the father returned, the patient first politely wished him "away," then developed nightmares, and required to be taken in to her mother's bed. In her dreams she saw her mother kidnapped, and herself as her mother's rescuer. She was so sleepless that she was given sedatives by a pediatrician. Thus, her scholastic concentration, production, and self-esteem suffered due to poor grades. Meantime, after beginning psychotherapy, she began romping with her father each evening, becoming pleasantly excited. Now, somewhat bewildered at her new orientation, she began having so-called "night terrors" again, without dreams or much excitement, but with a gentle request that either parent take her in bed. Then she became disobedient to her mother and wanted to be spanked to fixate attention on herself. Psychotherapy, partly through dramatotherapeutic projection aided by the clinic nurse, and self-expression in marionette and dollhouse play, brought out psychocatharsis and gradual change in the structure of her psychologic state with main reference to the direction of libidinal urges. Direct analysis was then used, parallel with mild hypnotic hypotaxic suggestions anent involving and defiantly challenging the nightmares

*Chief Neuropsychiatric Outpatient Clinic, Walter Reed General Hospital, Washington 12, D. C. (1947-1948). At present, Neuropsychiatric Consultant, Central Disability Board, U. S. Veterans Administration, Washington, D. C.

in a presomnic state every evening,[1] successfully counting on the conscio-subconscious interantagonism. Suggestion as to her mother's grief and possible loss of latter's beauty (another adored fetish) and, in case of no voluntary behavioral control, the need for mother's long rest away from the patient for three months, suddenly changed the symptoms. To please her adored mother, she first began to enjoy the thought of tomboyishness, instead of the previous mother-dependency, yet she exhibited a socialized form of intense penis envy. She still did not wish to be a girl, but was willing to accept the fact of her recent tenth birthday. Only later did she change her anti-masculine attitude, forgiving her little boy-companion who, without permission, dared to kiss her six months ago; she even put rouge on during a formal reception, wore a party-dress instead of dungarees, had a feminine coiffure and shoes, refrained from previous baby talk and from tomboyish behavior. Her school performance improved, her self-respect arose, her interest in music and other studies became noticeable, and she no longer considered herself "dumb." Her mother and father now had equal influence as a complex unit on her personality development, in a desired and salutary way. The insomnia disappeared after 22 hours' treatment, and the diagnosis was anxiety state with passive dependency reaction.

Case Two

A 21-year-old secretary had esthetic and philosophic interests. Since an early age she hated her domineering and loud mother because the latter would not enlighten her on sex matters, because the mother fought constantly with the beloved and much-pitied father and, finally, because the mother brought the patient into the world with a defect. An evil-smelling pus-secreting, persistent omphalomesenteric fistula made her feel inferior to other girls, suspicious of courtship by young men, and hopeless as to her eligibility in normal courtship and love. She and her beautiful sister, of whom she became jealous, fondled each other in bed; they wished their parents dead whenever they overheard the parents wishing one another dead. The patient had a number of adjustment difficulties at school, feeling discrimination because of her foreign origin, but she was brilliant in studies, especially in art and music. She was congratulated on her poetic and compository efforts. In adolescence, insomnia was followed by nightmares and nightwalking in which she was trying to "get away from home," yet in recurrent dreams she was agonizingly seeking to find entrance to her house. When she did find it and entered the house, only an infinitely empty immense space of the universe frightened her to full waking state. At 16, she doubted God and religion, found no substitute, developed a pessimistic world of her own, and became prone to

hermitism at 19. Once she hit father with a lamp and seriously injured his eye and face. Then followed a terrible recurrent nightmare in a half-waking state, in which a locomotive crashed through her room and against her forhead (*jus talionis*, self-punishment). She would suffer so that she would dream of a recurring obsessive image: her brain was a tomato and she tried to scoop it out so she could rest neutrally in a sort of nirvanic peace, and sleep deeply. She felt guilty for what she did to her father, then, unable to bear it consciously, she became confused, disoriented, had sensations of depersonalization and felt alienated to the world. She heard herself scream when in reality she was silent, heard herself talk as if the speech came from another individual, developed paranoid fears of her brother, and experienced the conscious urge to kill mother. She dared not sleep for fear of killing her mother. She cried about an entity-like torturing "Thing" in her brain. Before this writer met her, she was given insulin shocks without any improvement in her apparent schizoneurotic state. She improved when allowed to leave the private sanatorium. Her insight was very fair, but her judgment was poor.

Due to a more recent financial conflict between her mother and father, all symptoms beyond her martyr-like seclusion from the world and social parasitism became suddenly aggravated. She became particularly distrustful toward young mens' desire to court her, although she was very pretty, and she extended her hatred to them, for how could they be sincere in their courtship when her mother made such a grievous mistake in bringing a "misfit" like herself into the world? To punish her hated mother, she took another relative's fluodyne or hematoporphyrin solution and drank one ounce, with resulting severe symptoms, in order to scare mother with her twenty-first and most serious suicidal gesture.

The doctor could make a very valuable positive transference after the fluodine poisoning-attempt. She concentrated all her father-love on his supportive function as a father-substitute, thus striving to help the grieved but loved father over a difficult period of his life by her noble intention of really getting well. After the surgical removal of the fistula, which was the crystallized symbol of her mother-hatred, the symptoms abated. Her multifarious half-dream states and nightmares, her fear of going to sleep due to an alleged dread of killing mother in a somnambulistic (that is, ethically not responsible) state, disappeared rapidly; her misanthropic attitude toward young mens' courtship changed to a normal adult behavior in frequenting parties, dances, study classes. Her former fear of matricidal urges waned, and she became pleasantly indifferent to her mother. She also forsook her seclusive and paranoidally

tinged martyr-attitude, lauded her brother for emancipating himself by joining the army voluntarily and, further, became enlightened in insight, as demonstrated in her artistic and philosophic writings. She went traveling in order to experiment with self-protective adult independence rather than parasitic dependence on her father. She took a secretarial job with a doctor in New York. After a few months she was asked in marriage by a young student, whom she neither accepted nor rejected. She is going to wait until he has finished his studies as a consulting psychologist. Meanwhile, she assumed a much more responsible secretarial position in Cleveland with an orphanage, thus realizing her recently awakened interest in children. Prior to this, she had gone through a period when she fixated her love on a cat and even dreamed of having a cat-child instead of a normal baby. Her level of functioning became more normal than in the ten years prior to her treatment, but especially in the two years preceding the latter. The diagnosis was schizoneurosis, with anxiety-hysteric,* dissociated trends passive dependency reaction.

SUMMARY

The first case presented is that of a 10-year-old girl's inverted Oedipus complex, first led through phases of tomboyism and subsequently normal feminine orientation after psychoanalytic, dramatotherapeutic and hypno-suggestive therapy of twenty-two hours in five months, aided by sociotherapeutic instruction to mother. In this case, homosexual trends and their partial displacement on a fetishistic object, a saddle-horse, substituting the need for masturbation and uniting the child with the adored exemplary image of her equestrienne-mother, due partly to a prolonged absence of the father, occurred as a basis for the Oedipal jealousy-born insomnia as passive dependency.

In the other case the nightmare-studded insomnia and emotional overdramatization were associated with father-love and mother-hatred, an equal weight having been reached by the hysteroid anxiety values and by the schizoid mechanisms in close compound with one another. Here the original mother-hatred appeared, fundamentally, because of a projected blame due to the patient's being born with an omphalomesenteric fistula and the ensuing inferiority plus hatred towards the peccant parent. Here there was also seclusiveness, suicidal urge, martyrism, fear of sleep due to dread of matricidal compulsions, jealousy of a beautiful and matrimonially successful sister who was physically loved and admired by the patient, but who "went away." There was also paranoid projection toward one brother. Seventy-two hours of psychoanalytic treatment in

*Note: About one year after the assumption of her new position, this young girl married her fiancé. Several months later she visited the writer with her husband, who appeared to be happy in his choice of a wife.

eight months were necessary to bring about satisfactory social and intrapsychic adjustment. This ordinary Oedipus situation with passive dependency reaction was gradually resolved by transvaluation of the meaning of her body image and of life, and she was able finally to kill the crystallized and dynamized hatred, called by her the "Thing," that had haunted her for years. When the deathblow to this symptom, the "Thing," was dealt by Eros itself, she could again say yes to life.

UNCONSCIOUS HOSTILITY AND INSOMNIA

DR. L. S. LONDON*

The psychologic reasons for insomnia are traceable to basic conflicts between the instinctive forces (Id) and the acquired moral forces, which Freud designated as the superego. Every dream probably contains a representation of the instinctive ego and a representation of the superego. When in harmony these two forces produce sleep by means of dreams which are made up of pictures. This is done through a process of censorship. When no accord takes place during censorship, the person awakes and we speak of this as an anxiety dream. Many people say, "I never dream." This is not true, for if it were not for the dream we would be unable to sleep. Persons who suffer from insomnia have conflicts between their instinctive forces and their acquired morals. We could therefore not even live without the dream. To illustrate this, let me cite some actual case reports.

Case One

A 36-year-old man had been suffering from insomnia for six months. He complained of sexual impotence and paresthesia. He was troubled with compulsory thinking about extra-marital relations. His dreams, when he was able to sleep, showed a desire to get rid of his wife. He dreamed that she was kidnapped by "white slavers." In reality he was very sadistic to her. In kissing her he would bite her lips (symbolizing biting her genitals —transposition from below). He had both dejected and elated periods which were cyclic in form. In his dejected states he sometimes appeared dazed, as if in a state of epileptic equivalents. His insomnia was his most troublesome symptom, and the reason for seeking treatment. It was caused because his instinctive forces were not in accord with his moral forces. His sadism could not be sanctioned by his ego. On the other hand, there are many individuals who can induce sleep by creating phantasies of sadism.

Case Two

A 32-year-old physician suffered from insomnia. He visited ten psychiatrists and got no relief. He never remained long under treatment. One psychiatrist suggested marriage, and after a hasty courtship, he married. This only increased his insomnia. During his short analysis, he often expressed ideas that he felt effeminate and thought he should have been a woman. He ad-

*Practicing Psychotherapist, Washington, D. C.

mitted having thoughts during his insomnia of killing his wife, and in time these thoughts developed into compulsory thinking.

Case Three

A 32-year-old man suffered for several years from insomnia. While he created hundreds of phantasies at will, those that kept him awake were not under control of his will. These hatred phantasies seemed to develop more in intensity as his masturbation phantasies decreased, and continued to increase more even after heterosexual experiences. Usually the hatred phantasies were directed against his father who interfered with the imaginary love object of his masturbation phantasies. The reason for his insomnia was his ungratified libido, which was attached to a sheet (fetish) which he used in his masturbation. This sheet was related to his Oedipus complex (love for mother) who bathed him during childhood. His hatred phantasies were directed against his father because the imaginary love object was his mother, the phantasy love object in his masturbation, and when his privacy was invaded, the hatred phantasies kept him awake.

The idea that sexual frustration is the cause of insomnia is a moot question. The lack of sexuality may produce it, but I have had many patients who, although they indulged in sexual relations regularly, were unable to sleep. This may be explained in the following way: While the mere physical sexual cravings are satisfied, their libidinal urge is not gratified. The libido or creative force which is unconscious lives solely for its gratification, and this instinct cannot be satisfied in a perverse way, for if it could be, the race could not survive; so nature has endowed it with a desire to gratify itself, and when not satisfied, it may produce insomnia.

SUMMARY AND CONCLUSIONS

In the three cases reported, we note that unconscious hatred played the significant role in keeping the patients awake. Although two of them had a sexual life, there was no gratification of their libido. In other words, there was no desire to enjoy the sexual act. In the first and second cases both wanted to be rid of their sexual partners. In the third the hatred was centered around an Oedipus situation.

TENSION, ORGANIC-DISEASE PHOBIA, GUILT, COMPETITION AND INSOMNIA

DR. P. LITVIN*

In this discussion insomnia means the inability to sleep with all the subsequent symptoms, which are usually a lack of ability to perform, inability to concentrate, and, at times, a subsequent period of sleep. What the patient usually refers to as insomnia is not insomnia but some of the symptoms that are mentioned above. Since we know that these symptoms can be present in conditions other than true insomnia, the importance of these distinctions becomes evident. Insomnia exists in general medical conditions in which there is increased metabolism. For instance, it is not uncommon in hyperthyroidism. It is found in various neurologic conditions, such as parkinsonism, but in this there is often a reversal of sleep mechanism rather than a true insomnia. There are certain types of brain tumors that are characterized by insomnia. Although somnolence is the rule, every case of insomnia should have the most careful neurologic examination. Since hyperactivity is characteristic of an irritative lesion, it should be completely investigated before that lesion becomes one of total ablation of any cortical or subcortical center. The complaint of the patient, "I didn't sleep a wink last night," really does not mean anything unless investigated. Therefore, it is easy to see that a different treatment is required according to whether the patient is kept awake by the use of drugs, because of severe anxiety, or because he is in a manic phase. The important thing is to eliminate extraneous causes, as well as endogenous causes, before the insomnia is properly classified and appropriately treated.

The insomnia due to physical states that interfere with sleep should be treated with methods directed to their removal or their amelioration. For instance, the food gorger whose insomnia is based on overdistention should of necessity have his intake reduced. Sometimes this represents a psychologic cycle, since his eating may have a meaning not apparent on the surface. Sometimes the insomnia is traceable entirely to a psychiatric background.

Case On

A 36-year-old woman was referred because of inability to sleep, with a loss of weight of 24 pounds in eight months. She was referred when her doctors could not find anything to ac-

*Associate Professor of Neurology, Georgetown University Medical School, Washington, D. C.

count for her symptoms. It was apparent that she was anxious and quite concerned. She had to give up profitable employment and foresaw the possible loss of her career as an executive with a prominent advertising agency. Her history revealed that she had had severe anxiety for a number of years which she was able to "cope with until eight months ago." Her family history showed that her mother had undergone a similar episode at age 55, and that three years previously she had died suddenly, the postmorten examination revealing an unrecognized bronchogenic carcinoma. This patient had had extensive examinations, including endoscopic examination of the stomach and large bowel, and bronchoscopic examination. She was being considered for a laparotomy if her symptoms persisted. After several sessions, it was revealed that her symptoms related to her dread of having an incurable disease. She had been instrumental in working with the campaign to promote examinations for cancer. She had reviewed the copy and helped in the layouts, and each time she worked at this her insomnia increased to such an extent that the weight loss became noticeable. The anxiety was so severe as not to respond to the usual sleeping medications which had been prescribed for her before her referral. Study over a long period of time revealed that, although she identified herself with her mother, there were numerous instances in which she wished her "mother were not here." It seems that the attachment to her father was so close that her mother resented her, the patient stated. At the time that the mother was starting to have her symptoms the daughter tried to make light of them. She even discouraged her mother from seeking medical aid at first. When the mother died and the cause of death was discovered, the patient threw herself into her work "to overcome my grief." It was at a later date that she was connected with the cancer campaign. Because she felt that her symptoms were "like my mother's," she was convinced that she, too, had a hidden malignancy. The disease phobia was really based upon her own guilt feeling. After about three months of treatment she gradually gained insight into the reason for her own feelings and the subsequent symptoms. She was able to return to her previous status eventually, with no loss in her grade of employment.

Case Two

A 55-year-old man presented a picture almost similar, as to symptoms, to the previous case. In addition, he had one episode of hematuria, following a nocturnal emission. Extensive studies were done because "I am convinced that I have cancer of my prostate." Although concurrent diseases were found, namely a latent diabetes and a mild nephritis (revealed to the patient

early in the study), his symptoms persisted. At first no progress was made until one of his sons was interviewed. He off-handedly remarked that "Dad's old school chum died of cancer of the prostate several years ago." In following this lead, it was noted that this friend had really been his foster brother, unbeknown to his family. The patient blamed himself for having been instrumental in having him "thrown out of the house because he was my rival." The rivalry had apparently resulted from a competition for favors from the foster mother. A number of guilt feelings were revealed which "I have never told anyone else, doctor." The relief which followed the expression of his guilt feeling was more than noticeable. His insomnia improved and became an almost insignificant complaint. His anxiety continued but disappeared later. His symptoms were in the nature of self-punishment, to "atone for my unjust conduct."

These two cases show similar mechanisms. Both stem from strong guilt feeling having their origin in hostility and competition.

PARAPHILIAC PREOCCUPATIONS AND GUILT IN THE ETIOLOGY OF INSOMNIA

DR. B. KARPMAN*

Insomnia is one of the most frequent and one of the most annoying symptoms observed during the onset of mental illness, and is likely to persist throughout the patient's illness. Kleitman's prodigious review of the literature reveals clearly that general medicine and physiology have failed to give an adequate explanation or to institute adequate treatment for the condition, since sedatives and soporifics are of palliative nature at best. Barring the occasional instances of insomnia that come in the wake of organic conditions, insomnia is, for the most part, functional and often of psychogenic origin. Here we are likely to encounter two types, one due to immediate situations, as in the case of a student who is kept awake because of worries over pending examination and possible failure; and the deeper type traceable to unconscious motivations. It is not uncommon in a psychiatric institution, when asking a depressed patient the reason for his depression, to receive an answer such as this, "because I'm locked up in this hospital and I don't know how to get out." It is obviously the other way around—he is locked up because he is depressed. Similarly, when one questions a patient who suffers from insomnia, the usual reply is that he is worried when he cannot sleep. It is amazing how frequently such an answer is given, even by presumably competent psychiatrists, when asked the cause of their patients' insomnia; they answer that worries are responsible for the patients' insomnia, but they do not go beyond that to tell us what it is that the patient is worrying about. Psychodynamics, however, has a different answer. It submits that the insomniac is agitated by a type of mental conflict which is not acceptable socially; it is the worry and preoccupation with such problems that agitate and keep him awake. The psychodynamics of insomnia will perhaps be more clearly appreciated if presented in connection with a concrete case analysis.

A 27-year-old white man, whose services as a clerk in a business establishment were highly valued by his employers, recently decided to purchase a business establishment and gave a deposit of eight hundred dollars. As the opening date of the new business venture approached, he became more and more fearful of the great responsibility he would need to assume. Eventually he became so obsessed with this fear that he for-

*Chief Psychotherapist, St. Elizabeths Hospital, Washington, D. C.

feited his eight hundred dollar deposit and presented himself for analysis. In the interview preliminary to analysis his chief complaints were overwhelming fear of responsibility and insomnia. The second symptom is the primary concern in this study. The patient reported that he had never suffered from insomnia prior to his present illness, and that it was growing progressively worse despite the administration of numerous and diverse soporifics. The insomnia had grown so unbearable that going to bed was a "terror" for the patient, and the night was a succession of dragging hours. Snatches of sleep alternated with long periods of wakefulness. In addition, many times he would awaken and find himself shaking all over, his hands would tremble and his heart would beat rapidly. He stated, "My sleep doesn't give me any rest. I wake up without the confidence of having rested properly, like waking from ether—you wake up—here you are—your mind is blank . . . I wake up in the morning with the horror of facing work and tasks; I dread the future. I don't know what wakens me. Previously I could sleep so well and sound . . . one night I woke up ten times; woke up for a moment, thought I was my normal self and that the whole thing was a dream." In the early sessions, attempts to ascertain the patient's actual content during his nocturnal periods of wakefulness were unsuccessful, e. g., "I can't sleep; I have stomach pains. I seem to be two people because I don't seem to recall how I could be the way I was this monrning . . . I haven't slept properly for five nights . . . at night I dread the coming of the day . . . I still like to lie in bed . . . It seems that when I am in trouble I want to lie down and sleep." The patient reported, however, that before falling asleep he would often be troubled by thoughts of his mother and of his previous illnesses. After his third week of analysis, his associations suggested that his original statement that this was his first attack of insomnia was incorrect. New causes for insomnia were mentioned by the paient: (1) pictures of snakes appearing before him while lying in bed with his eyes open, followed by a fear of dreaming about these snakes if he were to fall asleep; (2) thoughts about his wife's desires for cunnilingus, accompanied by his own guilt feelings because he had originally persuaded his wife to submit; (3) thoughts about the failure of his wife to have an orgasm during intercourse, followed by feelings that he was responsible because he suffered from ejaculatio praecox; (4) thoughts about the fact that he often masturbated as a child to make himself fall asleep, as manifested in the following free associations, "Difficulty in going to sleep—then imagining a burlesque girl—tights—bare back—and I would be soothed into sleep. Masturbation before sleep would put me to sleep"; (5) thoughts concerning his prolonged attachment to his mother: "I heard father say that I was a great sucking baby, sucking my

mother's breast all night long, and that was the only way I could be put to sleep."

The above associations which he had first been unable to to recall on the conscious level, provide a clue to what was going on below the surface of conscious thinking. These associations are suggestive of the mental conflicts underlying and contributing to the overt symptom of insomnia. They deal with over-attachment to the mother (prolonged breast feeding), relief after masturbation, and preoccupation with perversions. The patient's present illness centered about the symptom of insomnia and amounted essentially to a retreat from the demand of a normal married life as well as from the demands of independent business activity. His perverse sexual practices had served to nourish unconsciously his strong Oedipus complex (prolonged mother attachment). In his masturbatory activity accompanied by images of degraded womanhood (burlesque girl), the patient was enabled to reserve all his psychic love for his mother and to think of other women (including his wife) in terms of perverse love. All his attempts at normal sex relations with his wife were failures and she served only as a medium for the continuation of his paraphiliac life. Just as he could not establish a business life independent of an employer, neither could he establish a sex life independent of his mother. The prospect of standing alone in business filled him with the same sense of insecurity that had resulted from his unsuccessful attempt at a normal marital adjustment. Inasmuch as his present desires lay in the realm of reality, masturbation no longer served his purpose. The thoughts about the claims of reality were responsible for his severe insomnia, whereas prior to his present life situation he had been able to lull himself to sleep with paraphiliac phantasies. In response to the demands of reality the patient experiences a new mental conflict. A desire is born to emancipate himself from the slavery of paraphilia so that he may progress in a non-perverted and independent fashion. In opposition to this desire is the tendency to move effortlessly along the well-worn mental pathways of long-standing paraphilia. The fear that he would never be able to separate himself from the perversions to which he had been succumbing is illustrated by the homosexual phantasy seen in the following association, "Daydream—lying on bed and brother wanted to play with me. I chased him off and he whispered, 'If you weren't going to the doctor, you would let me'."

He suffered from insomnia because sleep had become associated with the habitual indulgence in perversions from which he was trying to escape. This long-standing paraphilia contrasted sharply with his newly formulated conscious desires to become a non-perverted and successful individual.

SUMMARY

An analytic study of a case of insomnia revealed that, while at first the patient's explanation of the condition revolved around external factors and was purely descriptive, subsequent analysis revealed the mind's preoccupation with incestuous and perversive drives accompanied by a most torturing sense of guilt, which prevented proper sleep functioning. The cure was brought about when the conflict was resolved in favor of reality and a normal sex life.

INSOMNIA IN CHILDREN

DR. LEO KANNER*

Insomnia and restless sleep in early infancy are mostly the results of bodily discomfort produced by hunger and thirst, wetness, indigestion, tightness of the diapers, cold, or excessive heat. The baby gives vent to his malaise through the medium of crying, which is maintained until adequate relief is given or until his restlessness has been ultimately conquered by the physiologic need of sleep. Both in the infant and in the older child, any sort of physical illness may lead to conditions which, by means of continuous irritation, interfere with the required composure. The itching sensations of eczema or scabies, breathing difficulties caused by adenoid vegetation or head colds, alimentary disorders, pain arising from otitis media and other acute or subacute diseases may so influence the child that he either has difficulty in falling asleep or wakes up during the night. If he does manage to sleep through, he tosses about in his bed and does not have the feeling of freshness and vigor in the morning which is the natural effect of healthy sleep. The comparative dullness, irritability and poor scholastic achievements of the adenoid mouth breather are well known to school physicians; at least a portion of this reaction is based on restlessness at night and consequent uneasiness in the classroom. The therapeutic approach to these types of inadequate sleep is self-evident. It rests on the removal of the primary etiologic disorder.

In the majority of our cases, insufficient or restless sleep was not the chief complaint for which the children were taken to the clinic or referred for psychiatric consultation. Where bodily discomfort is not directly or indirectly responsible, the patients who jerk, jump, talk, and cry in their sleep are usually children who are also restless, overactive, and easily excited during the day. The nocturnal fidgetiness appears as an attenuated continuation of the child's diurnal reaction tendencies. Instead of immediately taking refuge in hypnotics or sedatives, the treatment, therefore, must attack the factors and situations which have driven the patient in the direction of increased motility. In addition to physical causes, general emotional and habit immaturity as the result of improper training may be found. The child may be under a heavy strain from being expected to do better work in school than his capacity permits. Or the home setting exerts a disconcerting influence upon him. Hence, even though the tossing and somniloquy occur in the

*Harriet Lane Home, Johns Hopkins Hospital. Associate Professor of Psychiatry, Johns Hopkins University Medical School, Baltimore, Maryland.

unconscious state of sleep, only a study of the patient's total personality and environment will help us to make proper plans for his relief by means of a satisfactory adjustment.

In dealing with children's sleeplessness, we cannot afford to omit a certain, not at all uncommon complaint of "insomnia" which really does not deserve this designation. Insomnia usually denotes the inability to sleep; this is rarely found in children unless they suffer from pain or itching, but unwillingness rather than inability is found in many children. Often the sleep difficulty is a part manifestation of general resistiveness. There are three equally dramatic scenes, some or all of which may be enacted in the individual case, as part features of the spoiled child "insomnia": (1) refusal to go to bed, with arguments, excuses, and delays; (2) rituals, crying, calling, playing after the child has gone to bed; (3) waking at night and calling for mother or father until the child has been "calmed" or taken into the parents' bed. Drugs are decidedly out of place in the treatment of this type of "sleeplessness." Here, as everywhere else in medicine and in mental hygiene, prevention is at least as important as therapy. Many people are in the habit of punishing children by putting them to bed, thus impressing upon them the notion that the bed is something undesirable, a punitive measure, something they have good reasons to resent. This idea is often strengthened by the would-be educational method of locking "naughty" children in dark rooms or closets and creating or suggesting fear of the dark. Regularity of retiring and getting up is as necessary as regularity in feeding. ("Regularity" is, of course, not synonymous with obsessiveness).

Much more fundamental and incisive is the complaint of sleeplessness which arises on the basis of disturbing obsessive preoccupations. Sometimes "insomnia" brings an obsessive child for the first time to a physician's attention. Sedatives and hypnotics fail to cope with the profound underlying anxieties.

Case One

A 10-year-old girl stayed awake for at least two hours after retiring. Since tonsillectomy under ether two years previously, she was afraid to go to sleep for fear that she might never awaken. This fear of death was aggravated by the fact that persistent tachycardia had led to the diagnosis of "potential borderline rheumatic fever," the prescription of complete rest and inactivity, and agitated apprehension on the part of the mother and physician.

Case Two

An 11-year-old girl, openly rejected by her alcoholic father, overprotected by her mother, and jealous of her younger sister,

developed a multitude of obsessive thoughts, which she never communicated to anyone until her second interview with her psychiatrist. She spoke of her preoccupations as her "worries," and felt guilty about them, especially those of a sexual nature. She lay awake for hours at night, "worrying about her worries." Administration of sedatives to relieve her "insomnia" always resulted in nausea and retching. Intensive psychotherapy brought about a better adjustment of the child and the family, a gradual diminution of her obsessions, and the incidental disappearance of her sleeplessness.

Case Three

A girl adopted when she was 10 weeks old got along well until the age of 6 years, when her adoptive parents took two refugee children into their home. The patient began to brood over her status and the difference between "own" children, stepchildren, adopted children, and refugee children. If the refugee children were to go back to England some day in the future, would she, who was also not her parents' "own" child, be sent away at some unspecified time? She tried to monopolize her mother. She woke up every night and cried until she was taken to her mother's bed, and was referred with the chief complaint of "insomnia." She was able, in several interviews, to vent her anxieties and to regain her security, and no longer needed her "insomnia" as a means of self-assurance.

ANXIETY AND TENSION IN THE PATHOGENESIS OF SLEEP DISTURBANCES

DR. F. R. RIESENMAN*

Insomnia is a common and sometimes distressing symptom. Rarely, it may occur alone as a single complaint; more commonly, it occurs in conjunction with other symptoms. Insomia is not always of pathologic significance, as most of us during our lives have experienced sleep disturbance incident to emotional factors related to some situation or event. It becomes of clinical import when it causes disturbance to such a degree that it interferes with the capacity of the individual to carry on his usual activities and renders him less efficient. Sleep is really a function of the parasympathetic component of the autonomic nervous system, and in this respect has its own anatomical level in the autonomic tree. The center is believed to be in the hypothalamus. There is also an awakeness center in the hypothalamus which may become dominant to the sleep center under certain conditions. Therefore we can then readily appreciate the dynamics of sleep disturbance from a psychogenic point of view.

Emotional conflicts generate a considerable amount of tension and nervous energy which result in anxiety. The cerebral cortex bears the brunt of a continuous bombardment by nervous energy, resulting in a spilling over of some of this excess energy into the autonomic nervous system, with the consequent channelization of energy into its component parts. The resulting symptoms will depend upon the portion of the autonomic nervous system (psychosomatic level) that is hit. We see the substitution of physical syndromes for mental conflicts. If the cardiac level is hit, we may have palpitation and tachycardia; gastrointestinal level may produce dyspepsia, constipation, diarrhea; cerebral level may produce headache, vertigo, insomnia and mental lethargy. Unless sleeplessness is caused by pain, organic lesions of the central nervous system, or advanced systemic organic disease, it may be considered a neurotic symptom due to emotional conflict. It is most often an index of anxiety within the individual. While it may be the most troublesome symptom, there are always other symptoms of emotional origin. The need for isolation so prevalent in persons with an inferiority complex is responsible for, or is concomitant with, insomnia in such instances. Sleep is one of the few biologic phenomena in which isolation is desirable. To the individual who suffers from an inferiority complex, and is therefore already isolated, sleep presents a major danger because it

*Staff, St. Elizabeths Hospital, Washington, D. C.

intensifies this isolation to a pathologic degree. The conflicts responsible for the disturbed psychopathology may be conscious or subconscious and/or situational. If conscious in character, the patient is rendered more readily accessible and amenable to psychotherapy. The source of the conflict must be sought in order to appreciate the underlying dynamics and mechanisms that contribute to the psychopathologic factors. Until the conflicts are resolved, the energy created by them generates a tremendous amount of anxiety which may be of the free floating type, but a portion may be bound up and channelized. This misdirected energy may interfere seriously with the normal sleep mechanisms by disturbance of the normal physiology of the sleep and awakeness centers in the hypothalamus.

Case One

A single woman, age 30, complained of a marked degree of insomnia. Aside from some feeling of tenseness and irritability at times, there was no other evidence of illness. She gave a history of difficulty in going to sleep for a period of five years. The symptom had become more severe in the several months preceding her visit and had reached such proportions as to interfere seriously with the discharge of her duties as a private secretary. It was only when she recognized that her disturbance was rendering her less efficient in her work that she sought medical help. From a superficial examination no explanation for her symptoms could be found, but on deeper probing, it was learned that she had not really found her place in life. She had been highly successful in the business world and derived much satisfaction and pleasure from her work. She held two college degrees and was highly intelligent. When asked if she ever thought of marriage, a home, and children, she remarked that no man in particular ever interested her to the extent of marriage. When asked if she thought this to be a normal viewpoint, she replied that probably the trouble was with her, since she had many proposals of marriage, but that no man had come up to her ideals of a husband. Inquiry into her history revealed that she was an only child whose mother died when she was young. The father was devoted to the child and she to him. He never remarried and when she became older she kept house for him. He was a fine man with an excellent character and high ideals. There was a close bond of affection between the two. She was keeping house for him at the time of her visit to the clinic.

The psychopathologic basis in this case was obvious. The strong emotional bond that had developed between her and her father was operating through the unconscious to prevent a normal emotional relationship and attachment to a member of

the opposite sex. This created conflict and tension with resulting insomnia. When insight into her illness had been established, she became more tolerant and realistic in her attitude toward men, and eventually her emotional needs for love, home, and family received expression through her marriage. Her symptoms disappeared and she was never bothered with insomnia afterward. The mechanism of sublimation, essentially incestuous and neurotic in origin, appeared to have satisfied her for many years. The satisfaction, however, it appears, was more apparent than real and the break came when the energy created built up to such a point that considerable anxiety and tension were generated, thereby rendering the ego control relatively insufficient with the appearance of neurotic symptoms or discharge phenomena. The drives could no longer be fully compensated for by a sublimation process alone and a compromise was no longer effective. In this case the symptoms of the relative insufficiency of the ego created through the state of being dammed up were of a positive type (affective), consisting of painful feelings of tension, of emergency discharge representing attempts to get rid of the tension, and spells of anxiety, irritability and restlessness, finally producing sleep disturbances due to the impossibility of relaxation.

SUMMARY AND CONCLUSION

The anatomic and physiologic factors involved in the sleep mechanism are discussed together with the psychopathologic and pathophysiologic aspects. The case report affords an excellent example of how anxiety and tension, as a result of unresolved emotional conflicts, generated energy which was ultimately dissipated over the autonomic nervous system at the cerebral level of the psychosomatic tree, and thus influenced the sleep and awakeness centers in the hypothalamus to assume pathologic proportions with the resulting insomnia.

PSYCHOGENESIS AND PSYCHOTHERAPY OF INSOMNIA

DR. JACOB H. CONN*

We spend one-third of our lives asleep. Sleep is one form, among others, in which the psychic processes are influenced by the vegetative nervous system. During sleep the threshold of stimulation is raised and "functional preparedness" is diminished. Sleep, like rest and relaxation, is a regenerative experience. From a constructive, normative point of view, it can be thought of as a creative pause. Apes and human beings learn a task better with an interval of sleep, and memory processes are more effective after periods of rest and sleep. Cobb has pointed out that consciousness cannot be contrasted with unconsciousness as if it were black versus white. It is better considered as being equivalent to a series of grays, and therefore consciousness becomes a matter of degree of wakefulness. We have all heard the story about the mother who becomes aware of her sleeping child's cry, although she slept peacefully while a storm was raging outside. Experimental evidence has demonstrated the same fact: that a sleeper can differentiate loud noises from nearby noises outside of the room.

Consciousness and sleep are total functions of an integrated organism and not just the result of nervous tissues in action. There is no simple psychologic or physiologic description of sleep. In fact, there are relatively few available objective physiologic factors. These accepted factors, according to Cobb, are: (1) more blood rather than less blood is present in the brain during the period of sleep, so that anemia plays no role in the normal sleep process; (2) there is a fall of temperature; (3) the muscles relax to a degree which parallels the depth of sleep; (4) there is slight acidosis and an increase of carbon dioxide; (5) certain specific electrical brain rhythms have been recorded. As awareness decreases and drowsiness begins, the alpha waves become less regular and spindles appear. As sleep progresses large slow potentials, six per second, appear, so that alert consciousness is associated with small, fast potentials and sleep is associated with large, slow potentials. These meager physiologic data have never been brought together in any consistent theory of sleep. From a clinical point of view we can start by thinking of sleep as being a continuum with the process of relaxation. Thus, we know that the hypnotic patient who is left

*Assistant Professor in Psychiatry, Johns Hopkins University Medical School, Baltimore, Maryland.

alone may fall asleep, and that the sleeping patient may be awakened sufficiently to serve as a hypnotic subject. Any type of tension, from simple, passive exercise to active interference and activity, and emotional distress will prevent sleep. Neurosurgical experiences have demonstrated that symptoms of agitation, depression, guilt feelings and insomnia cease following lobotomy. In each case it would seem that the lobotomized patient cannot anticipate discomfort. It has been demonstrated that pain is relieved by lobotomy for the same reason; the patient can no longer anticipate recurrent distress.

From a statistical point of view, it is interesting that complaints of insomnia are made by about 50 per cent of psychoneurotic patients, and this can be contrasted with the symptom of anxiety which is complained of by more than 80 per cent of a large series of psychoneurotics (857 cases), while the complaint of fatigue occurred in 70 per cent of these patients, gastrointestinal complaints were found in 60 per cent of the same (Stockbridge) series, headache in 20 per cent and nightmares were reported in 10 per cent of the cases. Insomnia is not sleeplessness, as has often been emphasized, but it is an attitude toward sleeplessness. It is a result of a basic anxiety shown consciously as a fear of the consequences of sleep or of not sleeping which mobilizes all the safeguards of the organism. In normal sleep we are able to let go, so that the muscles relax and personal vigilance is no longer needed. We then assume a posture which in the past has been found to be effective in promoting further relaxation, and by using the same bed about the same time of night we experience what we have experienced numerous times before, a sense of passivity in which the attention begins to wander aimlessly and reverie and memory fragments slowly merge into the dream process. Sleep, then, is a product of rhythm relaxation and relinquishing of all defenses. It is common knowledge that sleep, like happiness, cannot be pursued or commanded; it must come when it will. The insomniac patient cannot feel secure, nor let his attention wander into reverie and dreams. He is preoccupied, alert and vigilant. He is concerned that he will lose control and do something desperate, walk in his sleep and kill, be off-guard and be killed; he is concerned that he will go insane and do some "crazy" thing or that he will die in his sleep. In any event, he is panic-stricken, overwhelmed by emotional distress so that he cannot let go. He cannot relax and he cannot surrender control. He feels himself in constant danger from both an inner and an outer attack.

From a psychosomatic point of view, it is of interest that fear and anxiety produce more rapid alpha waves, and that even by imagining a terrifying situation the alpha waves can be blocked but then speed up to almost double the rate. In arti-

ficial guilt situations, such as in the detection of lies, there is an alteration of alpha rhythms when key words are presented. It would, therefore, seem to be a psychosomatic fact that with increased emotional tension there is dominance in the alpha wave pattern which is in contrast to what occurs in the sleep process (Lindsley). There also is the factor of hyperventilation which, as Gibbs has shown, markedly reduces the cerebral blood flow. Physiologic studies have repeatedly demonstrated that psychoneurotic patients tend to hyperventilate, so that this factor becomes significant since the amount of blood to the brain is increased rather than decreased in the normal sleep process.

From a psychic, economic point of view, dreams permit a mastering of disturbing emotional content by repetition, working through by symbolic representations. This type of psychic re-experience helps to make sleep possible and controls the degree of excitation. If warded-off impulses which push forward in the state of sleep, or before falling asleep, are not mastered, then an acute defensive conflict arises, with the result that sleep is disturbed. A number of patterns have been presented; sexual excitement without gratification, and any affect-laden expectation, whether it is fear and the need for flight, or the need for compulsive rituals, will disturb sleep. Every possible type of distress may contribute to insomnia. The disturbing influences may be bi-sexual conflicts, frustrated ambitions, rage, guilt, anxiety, fear, hate, paraphilia, jealousy, and preoccupation with murder and death. Here we have a veritable catalog of psychopathology, each item being an index of the tensions which contribute to insomnia. The neurotic's conception of himself as a weak individual who has not as yet begun to live, and therefore feels that he is very vulnerable and may die at any moment, frequently appears in my case material.

Case One

A 32-year-old man is afraid to go to sleep for fear that he might kill his wife as soon as he loses control of himself while asleep. He is the only son and has five sisters. As a boy he always thought that he would have been better off being a girl, and early in the treatment presented castration dream material. In 1944 he began seeing another woman and when his wife learned of it, he felt guilty and remorseful. Since he had not had extra-marital sex relations he could not understand why his wife was so vindictive about this platonic extra-marital affair. Since then he was afraid to look at another woman and constantly thought about his wife and her demands upon him. Whenever he would go out, he would think that it was his duty to return at the earliest possible moment. His sleep became so disturbed that

four 1½ gr. capsules of sodium seconal were not effective. One electric shock treatment was finally advised, which immediately reduced the tension and made effective psychotherapy possible.

Case Two

The patient wakes each morning at 3 A. M. feeling angry, hurt and depressed. She broods that her husband, whom she would like to help, has completely ignored her and no longer confides in her. She repeatedly thinks of leaving him or hurting him in some manner, but can think of no way to do so. She is terrified by his temper tantrums, feels frustrated and has developed a chronic tension state in which one of the presenting features is insomnia. This is a case of situational stress in a dependent masochistic individual.

Case Three

A 7-year-old girl awakened a year ago from a dream and has been apprehensive and fearful of going to sleep ever since. During a play interview, she re-enacted the original dream in which a witch and her husband are stuffed into a well by a child. She spontaneously stated that the child was herself, and identified the witch and her husband with her own parents. She is an inhibited child who for many months has been fearful of wasting paper in an art class, and concerned that the teacher might take away her clay creations. Some time previously she had heard that the teacher had done this to another child and since then has refused to work in clay. Her tense, over-solicitous mother has done her best not to frustrate the child, and the father, a kindly, understanding person, has done whatever he could to be of help. The child, however, now feels that the slightest argument between the parents represents a threat to her. She is uncomfortable with children who are more aggressive than herself. During a series of play interviews, she would beat up the dolls representing her mother and father. She became less inhibited and was encouraged to re-enact these scenes in the presence of her mother and thus found herself accepted, although she was exhibiting for the first time a self-assertive attitude. At present she is more secure and sleeps well, after a series of five sessions.

Case Four

A 40-year-old white man, competing for promotion with a fellow worker who was approximately the same age and same weight, was shocked to learn that his competitor had dropped dead. The patient immediately began to avoid doing the things that his competitor had done, thus he avoided putting his feet on the desk, and tried to keep away from a window which his

competitor had looked out of occasionally. Because of his feelings of guilt he imagined that he might jump through the window. He became increasingly more tense and found sleep impossible.

Case Five

The patient, age 22, is described as a passive, dependent individual. During the war he served aboard a munitions ship and became anxious that he might be blown up at any moment. At one time in his military career he was beaten up by a military policeman, for what the patient considered to be a minor infraction. Since then he had both daydreams and dreams at night of revenging himself upon this military policeman. He had great need to demonstrate to himself that he was a "man" and that he could beat up the policeman in the same manner that he had been beaten. At night he would awaken and find himself unable to move a muscle. The paralysis was transient and would clear up in a matter of minutes or if he were touched by another individual. This is an interesting example of a passive individual imagining himself to be an active, punitive agent and finding himself blocked and anxious. In this setting, he awakened from sleep and found himself literally paralyzed.

SUMMARY AND CONCLUSIONS

I. Insomnia may come in the wake of physical and organic conditions. Searching physical and neurologic examinations are therefore indicated in all cases.

II. By far the larger number of cases of insomnia are traceable to the operation of psychogenic factors which are of two types: a) casual—due to immediate environmental conditions, and b) due to deeper and underlying unconscious motivations.

III. Unconscious motivations may be of a great variety and are generally expressive of conflict between prohibitive instinctive cravings and cultural demands.

IV. Foremost among unconscious factors is guilt:

1. Quite universally, guilt is based on and stems from the Oedipus situation.
2. Guilt feelings stem from hostility, the latter based on rivalry and competition for parents' affection—oedipal jealousy.
3. Guilt feelings stemming from paraphiliac preoccupations which conflict with demands of reality.
4. The underlying guilt feelings do not always come to the surface as such but may attach themselves to incidental physical complaints which appear hypochondriacal; they may appear as anxiety or just general tension.

5. Insomnia associated with fear of death also usually stems from unconscious guilt.

V. Other Unconscious Factors:
   1. Excessive ambition that cannot be satisfied may also be responsible for states of insomnia. Emotional insecurity is often a stray factor in producing insomnia. On the other hand, the insomniac, because he cannot feel secure, is alert, vigilant and preoccupied.
   2. Sexual frustration, fear of loss of love or lack of adequate sexual gratification may cause insomnia, especially if the relationship does not satisfy the basic sexual ideal.
   3. Fear of death or fear of causing someone else's death, which in itself may be due to basic death wishes, is occasionally a contributory factor in insomnia.
   4. As a sado-masochistic reaction, insomnia may appear as an expression of self punishment in passive dependent individuals who during the waking hours of insomnia indulge in compensatory sadistic phantasies.

VI. In Infants and Children
   1. Insomnia and restless sleep in early infancy are mostly due to physical discomforts, hunger and thirst, or any physical illness leading to continuous irritation.
   2. In other cases of children, the patient who is restless at night is also restless, overactive and easily excited during the day. Such reaction is often traceable to a difficult home situation, to improper training that makes greater demands on the child than his capacity permits.
   3. Again, with some children it is unwillingness rather than inability to sleep, often a part of general resistiveness.
   4. Insomnia in children may also arise as the basis of disturbing obsessive preoccupation.

VII. States of insomnia due to psychogenic causes are entirely amenable to intensive psychotherapy and are curable when the psychodynamics are ferreted out.

"Methought I heard a voice cry 'Sleep no more!
Macbeth doth murder sleep'—the innocent sleep,
Sleep that knits up the ravell'd sleave of care,
The death of each day's life, sore labour's bath,
Balm of hurt minds, great nature's second course,
Chief nourisher in life's feast,—

Still it cried 'Sleep no more!' to all the house:
'Glamis hath murder'd sleep, and therefore Cawder
Shall sleep no more: Macbeth shall sleep no more.' "

Macbeth, Act II, sc. ii